Code Edit Bulletin

For Health Care Professionals

February 2014

We routinely review and update clinical, reimbursement, and administrative policies, as well as code editing and medical coverage positions. This document provides information about updates effective February 17, 2014.

To view new and updated policies in their entirety, please log in to the Cigna for Health Care Professionals website at (CignaforHCP.com > Useful Links > Policies and Procedures > Claim Editing Policies and Procedures).

ClaimCheck and ClaimsXten Updates

- ClaimCheck® is an automated code auditing tool developed by McKesson that we use to help expedite and improve the accuracy of processing claims for services provided by health care professionals. Effective February 17, 2014, we will begin using ClaimsXten™ (CXT), a new clinical code editing software also developed by McKesson, for medical and behavioral products.
- As part of our upgrade to ClaimsXten, 22 distinct new code editing rules will go into effect. These 22 new code editing rules are detailed below in the Policy Section of this document and are designated as "new CXT rules." Additionally, please note that the majority of our code edits that are now in ClaimCheck version 10 will continue to apply with no change when they migrate as part of our upgrade to ClaimsXten on February 17, 2014.
- New Code Edits, and National Correct Coding Initiative (NCCI) edits, will be applied to CPT and HCPCS codes introduced every January. In addition, updates to coding guidelines and NCCI edits will begin being applied on a quarterly basis with the use of the new ClaimsXten code editing software.
- As of February 17, 2014, our ClaimsXten software will be Knowledge Base Version 52 and NCCI Version 20.0 Column 1/Column 2 (incidental) and Mutually Exclusive code edits for all medical claims we process.

List of New ClaimsXten Rules

Name of Rule	Description
Add-On Code Without Base Code **and** **Add-On Code Without Base Code 2** (new CXT rules)	Add-On codes are CPT and HCPCS-defined codes that are to be billed in addition to a primary code during a session. An Add-On code cannot be billed as a stand-alone code. The AMA has assigned specific base codes for most add-on codes. The Add-On Without Base Code Rule recommends the denial of claim lines containing an add-on code where there is an American Medical Association (AMA)-defined base code which has not also been reported for the same customer and health care professional on the same date of service. The Add-On Without Base Code 2 Rule recommends the denial of claim lines containing an add-on code where a base code has not also been reported for the same customer and health care professional on the same date of service. The add-on codes contained in this rule do not have specific base codes defined for them in CPT or HCPCS. The add-on code has been associated with the specific CPT category of services to which the base code would belong. The policy will consider the CPT add-on code +90461 (each additional vaccine or toxoid component administered) for reimbursement only when reported with the CPT primary code 90460 (immunization administration for a patient through age 18 via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered) on the same date of service by the same physician or

Name of Rule	Description
	other qualified health care professional. According to AMA CPT guidelines, CPT 90460 should be used for each vaccine administered when the physician or other qualified health care professional provides face-to-face counseling to the patient/family during the administration of a vaccine. For vaccines with multiple components [combination vaccines], report CPT 90460 with CPT 90461 for each additional component in a given combination vaccine where face-to-face counseling has been provided. Per CPT guidelines, it is also appropriate to report CPT 90460 with an add-on code of 90472 or 90474 for immunization administration of each additional vaccine provided without face-to-face counseling. **Example 1** Code 90461 (Immunization administration through 18 years; **each additional** vaccine or toxoid component) is denied when billed by the same health care professional without the base code of 90460 (Immunization administration through 18 years; first component) **Example 2** Code 44955 (Appendectomy; when done for indicated purpose at time of other major procedure) is denied when billed by the same health care professional with a Chest X-ray 71010. The rule is looking for the major surgical procedure performed with the appendectomy such as a total abdominal hysterectomy (58150) or a partial colectomy (44140).
Anesthesia Crosswalk (new CXT rule)	In alignment with AMA/CPT coding guidelines, Anesthesia Health Care Professionals are to bill for anesthesia services by reporting the CPT code for anesthesia administration, and not the CPT code representing the surgical services. The American Society of Anesthesiologists (ASA) Crosswalk Table converts CPT procedure codes to anesthesia codes as appropriate when a claim for anesthesia services, as identified by provider type, specialty, or identification number, is submitted with other than a designated anesthesia code. The ASA Anesthesia Standard Crosswalk Rule identifies procedure codes for non-anesthesia services submitted by an Anesthesiology Health Care Professional that have a one-to-one relationship with anesthesia services as identified by the ASA. The Rule will replace that procedure with the appropriate anesthesia procedure code as specified in the ASA Crosswalk Table and the crosswalked code will be considered for payment.
Anesthesia Crosswalk 2 (new CXT rule)	Many non-anesthesia CPT codes often describe procedures that may be done in a variety of anatomic regions, while anesthesia CPT codes are specific to both procedure and region. The American Society of Anesthesiologists' (ASA) Anesthesia Multiple Crosswalk Rule will find claim lines submitted by an Anesthesiology Health Care Professional, with a non-anesthesia CPT code that has a one-to-many relationship with an anesthesia code. Unless documentation is provided with the initial claim, the non-anesthesia CPT code will be disallowed, as the appropriate anesthesia crosswalk cannot be determined. The claim may be resubmitted with the appropriate anesthesia code. **Example** Code 33513 (coronary bypass) is submitted by an anesthesiologist. The ASA Crosswalk table identifies that there are multiple options for the anesthesia code for this surgical procedure (00567, 00562 or 00566). Because there is no 1:1 crosswalk available, the claim line containing code 33513 will be denied.
Anesthesia Not Eligible (new CXT rule)	The ASA Crosswalk Table converts CPT procedure codes to anesthesia codes as appropriate when a claim for anesthesia services, as identified by health care professional type, specialty, or identification number, is submitted with other than a designated anesthesia code. The ASA Anesthesia Not Eligible Rule will disallow claim lines submitted by Anesthesia Health Care Professionals for non-anesthesia procedure codes that are not eligible to be crosswalked to an anesthesia procedure code. According to the American Society of Anesthesiologists (ASA), certain codes cannot be crosswalked for one of the following reasons: it is not a primary procedure code, anesthesia

Name of Rule	Description
	care is not normally required, it is a radiology service related to a diagnostic or therapeutic service, or it is a non-specific unlisted procedure code. **Example** Code 24600 (treatment of closed elbow dislocation; without anesthesia) is submitted by an anesthesiologist. The claim line is denied, as the description of CPT code 24600 identifies that no anesthesia is required for the procedure.
Assistant Surgeons and Assistants-at-Surgery	Assistant Surgeon (modifiers 80, 81, 82) and Assistant-at-Surgery (modifier AS) are processed per CMS designations to Allow or Not Allow. CMS Assistant Surgeon / Assistant-at-Surgery designations of "2" are allowed without documentation. Effective February 17, 2014, CMS Assistant Surgeon / Assistant-at-Surgery designations of "0" will require documentation with the initial claim submission. For more details, please see Reimbursement Policy #MAS (Modifiers 62, 66, 80, 81, 82 and AS) on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Claim Editing Policies and Procedures).
Base Code Quantity (new CXT rule)	Certain CPT procedure codes are used to report a primary service or procedure, or base code, which are only appropriately billed once per date of service. CPT provides add-on codes to report additional services associated with the primary or base procedure. When billing a base code procedure, additional services beyond the primary service or procedure should be billed with an appropriate add-on code. Quantities of base code greater than one will be disallowed and replaced with a new line with the same procedure code and quantity equal to one. **Example** Code 22610 (arthrodesis, posterior; single level) is billed with two units of service. There are no historical claims on file. The claim line is denied. A claim line is added with code 22610 with one unit of service and is considered for payment.
Bundled Service (new CXT edit)	Certain procedure codes are designated by CMS as "bundled" by a status code indicator of "B" on the CMS National Physician Fee Schedule Relative Value File. When billed with any other procedure code that is not indicated as a "bundled" service, these procedures are considered a component of, or incident to, the overall service provided, and separate reimbursement is not warranted. **Example** Code 36000 (introduction of needle or intracatheter, vein) will be denied when billed with any procedure code other than another "bundled" service.
Component Billed (new CXT rule)	The CMS National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. If a professional or technical component of a procedure is submitted and the same global procedure was previously submitted by the same provider ID for the same customer for the same date of service, the component service will not be additionally reimbursed. If a global procedure is submitted and a professional or technical component of a procedure was previously submitted by the same provider ID for the same customer for the same date of service, reimbursement will be adjusted to reimburse only the other component service (i.e. professional previously submitted; reimburse for the technical component). If a global procedure is submitted and a professional or technical component of a procedure was previously submitted by the same provider ID for the same customer for the same date of service, the component service will not be additionally reimbursed. **Example** Code 71110 (x-ray ribs) is billed with no modifier and the claim line is paid. The same health care professional submits a second claim for the same customer, code, and

Name of Rule	Description
	date of service, but this time Modifier 26 is added to the code. The claim line is denied as the global procedure has already been paid.
Co-Surgeon Modifier 62 (new CXT rule)	This rule identifies claim lines containing procedure codes billed with the co-surgery modifier (62) that have or have not met the criteria for co-surgery payment according to CMS. **Please Note:** Supporting documentation for the need of a co-surgeon is required for CMS Co-Surgeon Designation # 1 on initial claim submission. **Example** Code 59400-62 (global care for vaginal delivery) is submitted and the claim line is denied. Code 59400 is a designation 0 per the CMS National Physician Fee Schedule (NPFS) and is denied in accordance with that designation. Code 33363-62 (aortic valve replacement) is submitted and the claim line is considered for payment. Code 33363 is a designation 2 per the CMS NPFS. Code 22850-62 (removal spinal instrumentation) is submitted along with its corresponding operative report and a narrative from the co-surgeon indicating the need for co-surgeon services. The claim line is considered for payment. Code 22850 is a designation 1 per the CMS NPFS.
Deleted Code (new CXT rule)	This rule recommends the denial of claim lines containing deleted procedure codes when submitted after the deletion date of the procedure code. The health care professional is required to submit a corrected claim with the code that is valid for the date of service. **Example** Code 92980 (placement of intracoronary stent) was submitted for date of service 02/14/2013. The claim line is denied as code 92980 was deleted by the AMA/CPT on 01/01/2013.
Global Component (new CXT rule)	The CMS National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. A single health care professional can bill for both components (global procedure), or different health care professionals can each bill for different components. Claims for these types of procedures are paid up to the total of the global procedure (both technical and professional components combined). Any submission of the same procedure will be evaluated against previous submissions to determine if any or all components of the procedure have already been paid and the claim will be adjusted accordingly. If a global procedure is billed on a current line or support line without modifier –26 or –TC present in any modifier fields, and the claim facility flag = Y, the technical component (–TC) will be assumed. If a global procedure is billed on the current line without modifier –26 or –TC present in any modifier fields, and the claim facility flag = N, and the POS is Inpatient or Outpatient, the professional component (–26) will be assumed on the current line. Note: if either –TC or –26 have been paid in history, and a global procedure is reported (either a current claim line reported with both modifiers –TC and –26, or a claim line reported without any modifiers but with a facility flag of N and a POS not inpatient or outpatient) on the current claim line, the global component will be denied. A claim line will be added with the appropriate component to prevent overpayment. **Example** Health care professional #1 submits a claim for the global reimbursement of code 73600 (x-ray exam of the ankle) and the claim is paid. Health care professional # 2 submits a claim for the same date of service billing 73600-26. This claim line will be denied as the global reimbursement for 73600 has already been paid.
Global Obstetrics (new CXT rule)	This rule audits potential overpayments for obstetric (OB) care. It will evaluate claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy and postpartum period as applicable. Please view the policy on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful

Name of Rule	Description
	Links > Policies and Procedures > Modifiers and Reimbursement Policies). **Example** Code 59400 (total global care; vaginal delivery) is submitted for a single gestation delivery from Health Care Professional # 1 for a delivery date of service of 06/01/2013 and is paid. Code 59425 (antepartum care only-4-6 visits) is submitted by health care professional # 2 for dates of service prior to 06/01/2013. The claim line is denied as the global care reimbursement has already been paid.
Inpatient Consultations (new CXT rule)	A consultation is a type of service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. Furthermore, [If] subsequent to the completion of the consultation, the consultant assumes responsibility for the management of a portion or all of the patient's condition[s], the appropriate Evaluation and Management (E&M) service code for the site of service should be reported. An inpatient consultation for the customer, for the same diagnosis, within the 5 days following an inpatient consultation will be disallowed. The follow up service should be billed with a non-consultation CPT E&M code for the appropriate level of office visit, established patient or subsequent hospital care. **Example** Code 99253 with diagnosis 162.3 and 512.8 is billed by a health care professional on day two of an inpatient hospital stay and the claim line is paid. The same health care professional bills 99251 on Day three of the same inpatient stay with diagnosis code 512.8 and 528.0. The claim line is denied given that an inpatient consult was already paid for during the inpatient stay with the same diagnosis; in this case, a "Subsequent Hospital Care" code should have been used.
Medically Unlikely Edit (new CXT rule)	The Medically Unlikely Edit (MUE) Rule applies frequency limitations as defined by CMS. These edits were developed by CMS based on anatomic considerations, HCPCS or CPT code descriptors, CPT instructions, CMS policies, nature of service or procedure, nature of analyte, nature of equipment, and clinical judgment. This rule will disallow payment for non-facility claim services exceeding the MUE value for a CPT or HCPCS code across all claim lines by the same health care professional, for the same customer, on the same date of service. We are aligned with CMS Medically Unlikely Edits for frequency limitations. When CMS has no frequency designation for a procedure or service, we default to McKesson frequency edits for that procedure. **Example** Code 41116 (excision, lesion of floor of mouth) is submitted with five units of service for date of service 06/01/2013 by the same health care professional. The claim line is denied. A new claim line is then added with code 41116 and with three units of service. The claim line is then considered for payment. The CMS MUE is three for code 41116.
Missing Modifier 26 (new CXT rule)	This rule recommends the denial of claim lines containing a procedure code submitted without a professional component modifier-26 in a facility setting (POS 21, 22, or 24). The CMS guidelines establish that certain procedures performed in certain settings require billing of the professional component modifier. These codes are identified in the National Physician Fee Schedule Relative Value File. **Example** Code 70450 (CT of the head) is submitted without Modifier 26 and the place of service is 22 (outpatient hospital). The claim line will be denied. However, a claim line will be added with code 70450-26 and will be considered for payment.
Modifier to Procedure Validation (new CXT rule)	Modifiers provide a way to indicate that a service or procedure that has been performed has been altered by a specific circumstance. Certain procedures can be reported with a modifier that allows payment for services otherwise bundled, due to significant, separately identifiable services. We will not allow separate reimbursement for services reported with specific "payment-affecting" modifiers if the modifier is not appropriate for the procedure code billed. When multiple modifiers are submitted on a line, all are evaluated and if at least one is found

invalid with the procedure code, the line will be recommended for denial.

Example

Code 85025 (complete blood count) is submitted with Modifier 26. The claim line will be denied as the PC/TC Indicator for code 85025 is a 9 (concept does not apply). The code and modifier combination of 85025 and Modifier 26 is invalid.

Modifiers edited by this rule:

Modifier	Description
22	Increased Procedural Services
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
26	Professional Component (Laboratory services that are billed with Modifier 26 and have a CMS PC/TC indicator of 3 (Technical Component Only) or 9 (PC/TC Concept Not Applicable) will be denied.)
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
33	Preventive Service
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
66	Surgical Team
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
91	Repeat Clinical Diagnostic Laboratory Test
AA	Anesthesia Services Performed Personally by Anesthesiologist (Anesthesia health care professionals should be utilizing CPT designated anesthesia codes with an appropriate anesthesia modifier)
AD	Medical Supervision by a Physician: More than 4 Concurrent Anesthesia Procedures

AR	Physician Provider Services in a Physician Scarcity Area
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery
QB	Physician Providing Service in a Rural HPSA
QK	Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals
QU	Physician Providing Service in an Urban HPSA
QW	CLIA Waved Test (Lab codes valid with this modifier are aligned with CMS CLIA Waived Test list)
QY	Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist
QZ	CRNA Service: Without Medical Direction by a Physician
TC	Technical Component
QX	CRNA Service: With Medical Direction by a Physician

Never Event (new CXT rule)	We will not reimburse services identified as avoidable or should never occur, consistent with our reimbursement policy for Never Events and Avoidable Hospital Conditions. Please view the policy on the Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Never Events Fact Sheet). **Example** Code 27880 (amputation leg) is submitted with Modifier PA. The claim line is denied as there is no reimbursement for “never events.”
Never Event - Related Service (new CXT rule)	Services billed on the same date as a never event including hospitalizations and other services related to the never event procedures will not be reimbursed, consistent with our reimbursement policy for Never Events and Avoidable Hospital Conditions. Please view the policy on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Modifiers and Reimbursement Policies). **Example** Code 27880 (amputation leg) is submitted with Modifier PA for date of service 06/01/2013 by health care professional # 1. The claim line is denied. Code 01482 is submitted for date of service 06/01/2013 by health care professional # 2 for the same patient. The claim line is denied as there is no reimbursement for services related to a never event.
New Patient Evaluation & Management Code (new CXT rule)	This rule recommends the denial of claim lines containing a new patient E&M code when another claim line containing any E&M code was billed by the same health care professional within a three-year period. The new patient code will be replaced with the appropriate established patient code. Please view the policy on the Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures). **Example** Code 99203 was submitted by a health care professional for date of service 01/15/2012 and was paid. Code 99205 was submitted by the same health care professional for the same customer for the date of service 03/15/2013. The claim line is denied given that it is within the three-year period following the date of service of the first new patient visit. A claim line is added with code 99215 and the line is considered for payment.
Outpatient Consultations (new CXT rule)	A consultation is a type of service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem. Furthermore, [If] subsequent to the completion of the consultation, the consultant assumes responsibility for the management of a portion or all of the patient's condition[s], the appropriate Evaluation and Management (E&M) service code for the site of service should be reported.

	An outpatient consultation for the customer, for the same diagnosis, within 180 days following a previously submitted outpatient consultation will be disallowed. The follow up service should be billed with a non-consultation CPT E&M code for the appropriate level of office visit, established patient or subsequent hospital care. **Example** Code 99243 was billed with diagnosis code 250.4 by health care professional # 1 for date of service 06/01/2013 and the claim line was paid. Code 99244 was billed for the same customer with diagnosis code 581.8 and 250.4 by health care professional # 2 that has the same health care professional ID number as health care professional # 1 for date of service 07/15/2013. The claim line is denied as this was the second consult code billed from the same provider ID number, for the same diagnosis within a 6 month period.
T-Status Codes (new CXT rule)	This rule identifies claim lines containing T status procedure codes which are not payable when billed on the same date of service as any procedure payable under the physician fee schedule (defined as status A and R codes) for the same customer and health care professional. **Example** Code 94760 (pulse oximetry) is billed with code 99213. The claim line for 94760 is denied.
Team Surgeon Modifier 66 (new CXT rule)	This rule identifies claim lines containing procedure codes billed with the team surgery Modifier 66 that have or have not met the criteria for team surgeon payment according to CMS. **Please Note:** Supporting documentation listing the need for a team surgery is required on initial submission for a CMS Team Surgery Designation of 1. **Example** Code 32851-66 (single lung transplant) is received and the claim line is considered for payment. Code 32851 is a designation 2 per the CMS NPFS. Code 58605-66 (tubal ligation) is submitted and the claim line is denied. Code 58605 is a designation 0 per CMS NPFS. Code 22899-66 is submitted with its corresponding operative report and a narrative from the surgeon indicating the need for a team surgery. The claim file will be reviewed to determine if the team surgery was medically necessary.

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